DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

PLANNED ACTION NOTICE
ELIGIBILITY DENIAL, TERMINATION, OR EXPIRATION

CLIENT/APPLICANT NAME AND ADDRESS

REPRESENTATIVE NAME AND ADDRESS

Dear:

ELIGIBILITY DECISION

Effective _____ you are NOT eligible to be a client of DDD because:

☐ You do not meet the criteria for any of the eligible conditions specific to your age.

- ☐ Under age six (6) — WAC 388-823-0810 through 0850
- ☐ Age six (6) through nine (9) — WAC 388-823-0810 through 0850, WAC 388-823-0200 through 0710
- ☐ Age ten (10) and older — WAC 388-823-0200 through 0710

(See the enclosed Summary of Evidence and Evidence Table)

☐ Your eligibility expires on your — WAC 388-823-1005 and WAC 388-823-1040

- ☐ 4th birthday
- ☐ 10th birthday

☐ **Your disability originated at age 18 or older.** — WAC 388-823-0040

☐ **You are not a resident of Washington State.** — WAC 388-823-0050 and WAC 388-823-1020

☐ **Your disability is not expected to last indefinitely.** — WAC 388-823-0040

☐ **You or your representative requested termination of your DDD eligibility.**

WHAT HAPPENS NEXT?

☐ You currently receive paid services from DDD and the following services will terminate when your eligibility expires or terminates: (RCW 71A.16.020)

- ☐ HCBS Waiver Services
- ☐ Medicaid Personal Care
- ☐ Family Support Services
- ☐ DDD SSP Payments
- ☐ Other services

Your other available service options are:

YOUR APPEAL RIGHTS

You have the right to ask for an Administrative Hearing if you disagree with a **denial** or **termination** of eligibility. You do not have the right to appeal an **expiration** of eligibility.

You have ninety (90) days from the receipt of this notice to request a hearing. A request form is enclosed.

☐ **Denial** of eligibility. If this form notifies you that your request for eligibility has been denied, you may request an administrative hearing within ninety (90) days from the receipt of this notice. If you request a hearing more than ninety (90) days from the receipt of this notice, you no longer have a right to a hearing.

☐ **Termination** of eligibility. If this form notifies you that your eligibility has been terminated:

- You may request an administrative hearing by _____ to continue eligibility and any current paid service(s) during the appeal process.
- If you choose to continue paid services and the final decision upholds the department's action, you will be responsible to repay up to 60 days of paid services.
- If you do not want your paid services to continue, contact:

_____ at _____

CASE/RESOURCE MANAGER | TELEPHONE NUMBER

☐ **Expiration** of eligibility. If this form notifies you that your eligibility has expired because you failed to reapply for eligibility **in a timely manner** before your fourth or tenth birthday, you have no right to an administrative hearing. You may reapply for eligibility.

You have the following rights:

1. To be represented (you may be eligible for free legal assistance);
2. To request a copy of your file and all information reviewed by DDD to make its decision;
3. To submit documents into evidence;
4. To testify at the hearing and to present witnesses to testify on your behalf; and
5. To cross examine witnesses testifying for the department.

DO YOU HAVE QUESTIONS?

If you have questions about this eligibility decision or appeal process, contact:

_____ at _____

CASE/RESOURCE MANAGER

_____

_____

TELEPHONE NUMBER | OFFICE NAME AND ADDRESS

Washington State Department of Social & Health Services

DDD Division of Developmental Disabilities

PLANNED ACTION NOTICE DDD ELIGIBILITY DENIAL OR TERMINATION REQUEST FOR HEARING

per Chapter 388-02 for DSHS hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME | TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARING (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following eligibility or service decision by the Division of Developmental Disabilities (DDD):

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS OF PERSON REQUESTING HEARING	CLIENT ID NUMBER	
CITY STATE ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ **MESSAGE PHONE**	

I was notified of the decision on: _____ by: _____
DATE DSHS OFFICE NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ **Yes** ☐ **No** Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
ADDRESS CITY STATE ZIP CODE		

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ **Yes** ☐ **No**

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing, follow the instructions in the Notice of Hearing that will be mailed to you by OAH.

INSTRUCTIONS FOR DDD ELIGIBILITY PLANNED ACTION NOTICE FOR DENIAL, TERMINATIONS, EXPIRATIONS

Notification Requirements

1. The Planned Action Notice must be sent within 5 working days of the decision date.

2. The Planned Action Notice has five (5) sections.

    - Decision
    - Appeal rights
    - Summary of Evidence
    - Evidence Table
    - Request for Appeal

3. The Planned Action Notice is addressed to the client regardless of their age and to their representative per WAC 388-825-100. Use the following order to determine who represents the client:

    - A parent if the client is less than age eighteen (18);
    - The guardian or other legal representative;
    - Other relative;
    - Other person identified by the client;
    - An advocacy agency.

Completing the form

1. Effective date

    - Initial denial is the date generated by the IE application.
    - Expiration is 4th or 10th birthday.
    - 18 year old review is 18th birthday (allow a minimum of ten (10) days from the date of mailing and a maximum of ninety (90) days)
    - For other reviews, terminate the last of the month allowing a minimum of ten (10) days from the date of mailing and a maximum of ninety (90) days from mailing date.

2. Services: For terminations/expirations, check one of the boxes related to paid DDD services.

    - Check the DDD services that terminate with the eligibility.
    - You do not have to send an additional service Planned Action Notice since the "action" is the eligibility decision.

3. Other service options: Identify other DSHS and non-DSHS service options.

4. "Your Appeal Rights": Check the correct decision. At least one box must be checked.

    - If it is a termination of a currently eligible client, you must fill in the date for requesting a hearing and maintaining eligibility and services.

      The appeal date is calculated by counting 10 days from the mailing of the Planned Action Notice and extending to the end of the month of the 10th day.

        - The appeal date must be prior to or the same as the effective date. (See #1 above)

        - The 10th day must be a working day.

Examples:

1. The notice is completed October 10th with anticipated mailing October 11th.
   - Ten (10) days counting October 11th is October 20th.
   - the last day of the month of the 10th day is October 31st.
2. The notice is completed October 20th with anticipated mailing October 23rd.
   - Ten (10) days counting October 23rd is November 1st.
   - the last day of the month of the 10th day is November 30th.

5. Summary of Evidence

   - Complete the Summary section(s) relevant to the applicant/client age.

     - Children under age six (6): send only the Evidence Table "Children Under Age Ten (10)"
     - Children age six (6) through age nine (9): send both Evidence Tables
     - Persons age ten (10) and older: send only the Evidence Table for "Persons Age Six (6) and Older"

Distribution

1. The client and representative letter can be mailed in the same envelope if they live at the same address.
2. Put a copy in the client file.
3. Allen/Marr Class Members (see policy 11.01 and 11.03)

   - WPAS
   - RSN
   - MH CRM
   - Mental Health Program Manager in DDD Headquarters

SUMMARY OF EVIDENCE

BASIC REQUIREMENTS FOR DDD ELIGIBILITY

SUFFICIENT EVIDENCE	INSUFFICIENT EVIDENCE	DOES NOT APPLY	BASIC REQUIREMENTS FOR DDD ELIGIBILITY	DSHS REGULATION (WAC)
			(1) You are age six (6) or older and have a disability that is attributable to one or more of the following:	388-823-0040 (1)(a)
			(a) Mental retardation, or	
			(b) Cerebral palsy, or	
			(c) Epilepsy, or	
			(d) Autism, or	
			(e) Another neurological condition, or	
			(f) Other condition that is found by DDD to be closely related to mental retardation or requiring treatment similar to that required by individuals with mental retardation;	
			and	388-823-0040 (1)(b)
			(2) Your disability existed before age 18;	
			and	388-823-0040 (1)(c)
			(3) Your disability is expected to continue indefinitely;	
			and	388-823-0040 (1)(d)
			(4) Your disability results in a substantial limitation of adaptive functioning.	
			Or	388-823-0800 (4)
			(5) You are under age 10 and:	
			(a) You have developmental delays, or	
			(b) You have Down Syndrome, or	
			(c) Your condition is too severe to be assessed, or	
			(d) You are eligible for the Medically Intensive Home Care Program	

Note:
"Insufficient evidence" means no evidence received or evidence does not meet WAC criteria. See attached Evidence Table for specific WAC requirements.

If you are age ten or older, requirements (2) through (5) will be marked as "does not apply" unless you meet an eligible condition listed in (1).

If you are under age six, requirements (1) through (4) will be marked as "does not apply" with the following exception:

- Requirement (4) applies only to the condition of developmental delay.